AMA's Response to:

Alberta Health's Insured Services Consultation

This material has been assembled on behalf of the physicians of Alberta

DECEMBER 18, 2019

ALBERTA MEDICAL ASSOCIATION

AMA RESPONSE TO ALBERTA HEALTH'S INSURED SERVICES CONSULTATION

On November 14, 2019, Alberta Health introduced at the negotiating table, a set of proposals referred to as an 'Insured Services Consultation'. The government's bargaining team indicated they wanted a separate and distinct process from negotiations that would allow them to fulfill a need to consult with the AMA on a number of initiatives which they intend on implementing over the coming months outside of the current bargaining structure.

Alberta Health provided a timeline for the consultation process to occur, beginning November 14 and ending on December 20, 2019.

Consultation Process

Despite the short time frames, the AMA undertook a wide-ranging internal consultation process to assess the proposals. This process included:

- Review by several AMA committees and the AMA Board of Directors.
- Review by AMA sections.
- A series of AMA President letters to physicians.
- A province-wide distribution to all members of the AMA.
- Development of a web portal for members to share their perspectives.
- A special meeting of the AMA Representative Forum that was held on December 7.
- AMA participation in Working Group meetings with Alberta Health to fully understand the proposals and to discuss impacts/unintended consequences.
- AMA staff assessment of the proposals.

It would be an understatement to indicate that these proposed changes have created significant concern and stress amongst the medical community. To date, the AMA has received over 1500 comments from physicians. Physicians have expressed deep concerns with the proposed changes, and many provided concrete examples of how these will devastate their clinical practices and potentially lead themselves and their colleagues to consider a move to another province.

General Observations on the Consultation Items

Through its review of the consultation proposals and the extensive feedback received from our medical leaders and membership, there are a number of general concerns with the consultation proposals and process:

1. The proposals do not honor our existing agreements

The 2011-18 AMA Agreement, along with 2016-18 and 2018-20 AMA Amending Agreements, prescribe the processes in which fee and compensation matters are considered. This covers the current 2018-20 period plus any bridging to a new agreement via "evergreen" clauses. In addition, the AMA, Alberta Health and Alberta Health Services have negotiated a Strategic Agreement to govern negotiations of AHS physician compensation. These agreements describe in detail how compensation matters should be addressed, and include the ability to resolve disputes via binding interest arbitration.

The AMA is of the firm view that any fee and compensation related items that are being proposed for implementation ahead of the next agreement should follow the structures outlined in our current agreements. Any fee and compensation items proposed to be implemented in the next agreement should be discussed at the bargaining table.

2. The scale of what is being proposed

Notwithstanding the jurisdiction issue above as well as the merits (or lack thereof) of individual items, the AMA has some serious concerns regarding the scale of these changes which represent approximately $400M or 10% of total physician compensation. If all were implemented, the average Alberta physician would experience a $47,000 per year reduction in payments.

This one year change, proposed through a consultation versus a negotiation process, is more significant than any single year changes in the history of Alberta Medicare, and more than doubles the "Klein cuts" implemented in 1995. The cuts to physician compensation go against what the AMA understood were promises from the Minister to not cut front line health care spending.

3. The maldistribution of impacts on sections

The extreme maldistribution of financial impacts leads us to believe that there was little to no consideration of how the proposed changes would impact individual sections and groups. Our estimate of the financial impact by section (Appendix B) shows a significant reduction to family medicine ($61,000 per physician), as well as specialties providing a high proportion of hospital-based care (e.g. $48,000 for internists, $59,000 for gastroenterologists).

Within the Section of Family Medicine, impacts are also expected to be maldistributed, with those providing comprehensive, continuous care under the medical home model bearing a disproportionate burden. And within this group, rural family physicians providing these services, while at the same time providing after-hours coverage for their rural emergency rooms are expected to be hardest hit. This

impact is compounded by the recent and unilateral AHS changes to on call rates that have reduced payment for call by up to 37 percent for these physicians.

Some physicians have indicated that the proposed changes combined will reduce their net income (after overhead) by up to 50 percent.

4. Inconsistency with AMA/Alberta Health system objectives

It is particularly difficult for the AMA to comprehend the wisdom of these changes in light of the government and AMA's joint objective to build a strong primary care health system following principles of the patient medical home. The changes also appear antithetical to policies to address acknowledged challenges in recruiting and retaining family physicians in rural Alberta.

5. Alternative Funding Models

As part of AMA Agreement negotiations, the AMA is seeking government support for three key concepts to incentivize physician uptake and acceptance of clinical Alternative Relationship Plans in Alberta:

a. The importance of genuine partnership when providing health care through clinical ARPs.
b. The value of physician and AMA ARP Physician Support Services (ARP PSS) expertise.
c. The adoption of clear, shared priorities between Alberta Health, Alberta Health Services (AHS) and the Alberta Medical Association.

Some of the proposals (e.g., complexity modifier, comprehensive care) were presented by government with the suggestion that ARPs are the desired vehicle for physicians to provide comprehensive, complex care. From further discussions with government representatives, there appears to be some intent to 'de-incentivise' the Fee-For-Service system whilst opening up the cARPs to the point that more physicians would move into these plans.

The AMA is interested in building upon a fair process for physicians to consider the option of ARPs. This includes a streamlined, principled, contractual process (and fair dispute resolution mechanisms) with access to change management support and a governance structure where all parties are fairly represented.

Alberta has the highest percentage of FFS billing physicians of any province and accordingly the fee schedule has evolved and adopted innovative ways of remunerating physicians to provide comprehensive and complex care. There remains interest amongst physician groups with cARPs but the reality is that there are no cARPs in place that can be scaled significantly in the short to medium term. As an example, expansion of primary care capitation models (ie. Blended Capitation, Crowfoot and Taber) would quickly experience capacity bottlenecks with joint AMA/AH change management resources and with Alberta Health's ability to manage payments. It is therefore unrealistic to assume that physicians could somehow enter cARPs to avoid the significant and devastating consequences of these proposals. It is imperative that fee-for-service incentives align with our joint objectives to provide high quality primary and specialist care for patients with complex medical needs.

6. Short term gains (for government) at expense of long term costs and value for patients

In a wider context, the government's desire to strip away essential elements of the medical home and defund hospital-based care have a very real potential to increase costs in the future. There is clear evidence that continuous, comprehensive, team-based primary care leads to better patient outcomes and lower acute care costs through reductions in hospitalization, reduced ER visits, etc. We can only conclude that removing incentives to provide this type of care will create adverse impacts on patient care and acute care costs in the future. Similarly, removing incentives for physicians to provide service in hospitals will potentially lead to significant shortages of physicians willing to provide these services (we would note that this was the original rationale for negotiating these payments). It will be both difficult and costly to incent physicians back into hospital-based practices in the future to address this problem.

As was noted in the AMA President's Letter of December 11, these "proposals are penny-wise from a cost-cutter's perspective, but pound-foolish from a system perspective. The Medical Home is an important example of cost efficiency combined with enhanced quality care. This is value."

7. Timeframe

While the AMA recognizes the government's desire to find short-term savings in the Schedule of Medical Benefits, the Association is of the strong opinion that rushed proposals that don't reasonably explore the impacts and potential unintended consequences are neither appropriate nor constitute good public policy.

We would also note that full details of the proposed changes in AHS compensation (proposals 8 and 10) have not been forthcoming from AHS, making it difficult to consult with our members and provide an adequate commentary on these items.

8. Legal Concerns

AMA believes many of these items are rate changes and while we were willing to go through the consultation process, we reserve the right to keep these matters on the table during negotiations.

The AMA's recognition clause obliges the Minister to recognize AMA as the exclusive representative of physicians on "compensation matters". That term is defined as meaning "…the rates for benefits payable for the provision of insured services by a physician." Rates for the payment of medical benefits are established in the Schedule of Medical Benefits.

Therefore, any effort on the part of government to unilaterally change a fee in the SOMB would be in contravention of the AMA Agreement with the cogent argument that any rate changes are subject to negotiation with the AMA and, if performed during the financial term of any agreement, would need to be put before the Physician Compensation Committee for consideration.

A brief legal opinion on this matter is included in Appendix C.

9. Categorization/Disposition of Items

The AMA notes that the proposals represent a diverse mix of SOMB fee reductions, de-insurance, administrative changes and AHS payment changes. Different strategies should be employed depending on the category under which they fall. The AMA's categorization and recommended disposition of the items is as follows:

Alberta Health Proposed Change	Recommended Disposition
SOMB Fee/Rate Changes Proposal 1 - Complex Modifiers Proposal 2 - Comprehensive Annual Care Plans Proposal 5 - Diagnostic Imaging Billing Changes Proposal 6 – Daily Caps Proposal 7 – Overhead	• Proposed fee/rate changes need to be discussed at the bargaining table for the 2020 AMA Agreement • Any changes contemplated prior to the next AMA agreement, must follow the terms of the current 2018 AMA Amending Agreement
De-Insurance Proposal 3 - Driver Medical Exams for patients 74.5 years or older Proposal 4 - Payments for Diagnostic Imaging Services from Uninsured Practitioners Referrals	• Changes are within the Minister's purview. AMA recommends public consultation to fully understand the impacts of these changes.
Administrative Changes Proposal 9 – Submission of Claims within 60 days of service Proposal 11 – Stop Accepting Good Faith Claims	• Changes are within the Minister's purview. The AMA has a number of concerns as outlined in the attached appendix.
AHS Payments Proposal 8 – Clinical Stipends provided through AHS Proposal 10 – Non-invasive diagnostic fees in AHS facilities	• Changes to AHS compensation for clinical services are governed under the terms of the AMA/AHS Strategic Agreement. • Any changes to the Strategic Agreement should be addressed at the AMA Agreement bargaining table

A more fulsome assessment of the individual proposals including physician feedback, follows in Appendix A. This appendix includes a summary of the potential impacts and unintended consequences by proposed item.

While the Government's primary/overriding focus appears to be on cost savings, Alberta Health staff have also highlighted some of the concerns that prompted these proposals. In our assessment, we provide some commentary on how these other concerns may be addressed.

Next Steps

In conclusion, proposals 1, 2, 5, 6, 7 are not supported by the AMA and need to be brought forward to the negotiating table for further discussion. In addition, the groups impacted by proposals 8 and 10 are identified and referred to the AMA for access to due process via the Strategic Agreement. While we request fairness in application, including full consideration of AMA's commentary and a process for consultation with patients, proposals 3, 4, 9 and 11 should be handled at the Minister's discretion.

The AMA has a long history of working with government to ensure a high quality and affordable health care system for Albertans. Physicians of Alberta take very seriously their role as stewards of health system resources and are willing to work with the government to identify cost pressures and strategies to overcome them. Over the next few months it will be imperative that we work collaboratively to ensure that strategies to help address the government's fiscal concerns treat physicians fairly and equitably while avoiding any adverse impact on patient care.

Appendix A: AMA Item-by-Item Assessment of Insured Services Consultation Items

Proposal 1 - Adjust the Complex Modifiers

Alberta Health has proposed to increase the base unit of time spent on managing patient care for visits with time release modifiers and de-listing CMXV15, CMXV20, and CMXC30. This would include the following changes:

- Adjusting the CMGP01 modifier to begin at the 25 minute mark rather than the current 15 minute mark. Family physicians would be paid the same rate for a 25 - 34 minute visit as they are currently paid for a 15 minute visit.
- Re-specifying the CMXV15 to begin at the 30 minute mark versus 15 minutes. Physicians would be paid the same amount for a 30 or more minute visit as they are currently paid for a 15-29 minute visit.
- Re-specifying the CMXV20 to begin at the 30 minute mark versus 20 minutes. Physicians will be paid the same amount for a 30 or more minute visit as they are for a 20-29 minute visit
- Re-specifying the CMXC30 to begin at the 45 minute mark versus 30 minutes. This impacts comprehensive assessments and consultations.

The estimated impact is a reduction in payments of $200.2M (about 5% of the physician base), of which $173M would be GP payments (about 11% of the GP base).

AMA Response

This item represents a significant change in payments to physicians which should be moved to current processes under the AMA Agreement and/or the bargaining table.

These changes would have profound implications for the way that medical services are delivered in Alberta. Complex modifiers were introduced in the early 2000s and amended over time to recognize section concerns that visit and consultation services should provide recognition of patient complexity. Patient complexity is not solely the result of the patient's diagnosis, as it also includes other factors such as social determinants of health, mental health, learning disabilities, work stress, chronic pain etc.

Complexity modifiers recognize the time and the efforts spent providing total physician care and coordination for the patient. The outcomes for patients with coordinated care and a primary care physician are much better, acute episodic care is diminished and patient engagement and satisfaction is higher. The CMGP01 modifier in particular is viewed as a "flagship" code to support family physicians providing patient medical home services in a fee-for-service context. In 2018, the Section of Family Medicine proposed higher rates for the CMGP01 linked to patient attachment. This was not possible at the time due to the status of the Central Patient Attachment Registry (CPAR) and its ability to interface with the current claims system.

Alberta Health's proposal to effectively eliminate CMGP01 is in stark opposition to the Section of Family Medicine's strategy to support the medical home.

To date the AMA has not received from Alberta Health any evidence to back the claim that complexity modifiers have not improved clinical outcomes.

Impact or potential unintended consequences

- The Impact of these changes would be far greater for physicians who provide longitudinal, comprehensive, complex care for their patients than it would for other groups. This will include family physicians doing medical home-type work, and general internists who take care of some of the most complex patients.

- The proposed changes would create significant inequities. The Section of Family Medicine would be most impacted and, within this group, family physicians providing medical home primary care would be disproportionately affected. Over time, family medicine, as well as other sections (pediatrics, internal medicine and its subspecialties) financed the current complex modifier system out of their own fee allocations, foregoing other fee increases because this was important to them. This change will disproportionately impact these sections, while allowing other specialties who chose to use their funds to increase other rates or introduce rule changes to retain the benefit of those dollars.

- Physicians may limit their services per session, in order to keep the tasks that they can do within 25 or 45 minutes. This may in turn require patients to make multiple appointments.

Key Themes from Physicians (from approximately one third of all comments received)
The proposal will:

- Bankrupt comprehensive care physicians and non-procedural specialists.
- Cause walk-in style medicine, one visit one problem.
- Result in physicians choosing non-complex patients on their panels leaving patients with chronic pain, cancer, addiction, unstable diabetes etc. to the emergency room.
- Create a mass exodus of physicians leaving the province.
- Cut deep in rural Alberta and cause irreparable damage.

Key Quote

"To put it simply, I am extremely afraid and frankly panicking about what my practice will become if these cuts are implemented. I have thought of moving away, changing my practice as discussed above, or simply closing my practice and relying solely on my husband's income to take care of our family. If I will be made to see double the number of patients in a day than I currently see to make ends meet: I will be exhausted, I will provide sub-par care to my patients, and ultimately become too jaded to care. These sacrifices are too much and I am very afraid. My complex patients need me to be present and willing/able to take care of them. If these funding cuts to primary care are implemented, we will all lose."

AMA's advice

Alberta Health staff have indicated that part of the rationale behind these changes is the potential inappropriate billing of these modifiers. While the proposed changes are not supported, the AMA is willing to work with Alberta Health on a multi-pronged strategy to improve billing of complexity modifiers. Strategies may include billing education and peer review, linkage of GP codes to patient attachment, restructuring of time-based fees and enhanced Alberta Health compliance activities.

Proposal 2 –Comprehensive Annual Care Plans

Comprehensive annual care plans are written plans signed by both the patient and the care provider that lay out a plan to help patients understand and manage their complex medical conditions.

AH is proposing to remove the comprehensive care plan (03.04J) as a distinct service in the SOMB. It will not be de-insured but instead (when performed) be considered a component of the comprehensive visit (03.04A). Alberta Health expects to save $46.3M in payments to general practitioners (representing approximately 3% of family physician payments).

Key themes from physicians

- This has helped provide additional resources for the patients and has improved outcomes for the patients.
- There are other conditions that would benefit from a care plan.
- Care planning and a comprehensive visit are two completely separate activities and should be treated as such.
- With the extension on the time requirement for the 03.04A this service becomes valued even less.

Key quote:

"The comprehensive care plan allows us to take the time to assess the patient's general medical status as a whole. With this removed, patient centered care will diminish, we will likely miss medical diseases, and there will be more medical complications in the community. More physicians will refer to specialists, who will be limited to 50 patients per day, that will cause even further back ups and more patients with out of control disease states."

AMA Position

AH introduced the 03.04J and proposed it as a dual benefit for the patient. It would enable physicians to educate and engage patients in self-management and awareness of their complex needs. In addition, AH's Bulletin (Special Edition) indicated it was a way to compensate physicians for the time and efforts to manage patients with complex conditions, assist in the overall coordination of good patient care, improve communication between patients and their primary care physicians, and improve collaboration among multiple health providers. AH published that the 03.04J payments would "provide the remuneration to support the continued development of chronic disease management and primary care strategies currently underway in Alberta."

This underlying rationale still holds true. When they provide this service, physicians engage their staff to collaborate in the development and maintenance of the patient's care plan. Patients receive advice about self-management and overall principles to health improvement. The physician coordinates information in a single document that will educate and engage the patient in their overall health improvement and strategy while incorporating their values, beliefs, and living situation.

The service has been recently tightened to apply weekly limits and help ensure that the patient's family physician provides the service. The AMA has proposed further tightening to ensure it is appropriately targeted, as outlined in the advice section below.

Impact or Potential Unintended Consequences

- Coupled with the removal of the complex modifier, AH is removing the incentive for physicians to provide coordinated, comprehensive care to patients with chronic diseases.
- Less funding will be available overall for clinics to hire staff (e.g. nurse educators) to assist with chronic disease management.
- Patient engagement and self-management may decline, leading to more episodic care rather than a coordinated comprehensive care strategy.
- Fewer educated patients could result in more frequent use of more costly resources, including emergency room, hospital and specialist care.
- There may be an increase in polypharmacy issues with patients suffering from multiple comorbidities whose care is not being coordinated, resulting in increased visits and use of more expensive resources.

AMA's Advice

The AMA recognizes that this health service code could be further adjusted in order to provide better value for patients. As one example, the Section of Family Medicine has previously recommended that the code be restricted to paneled patients through the Central Patient Attachment Registry, once links have been put in place with Alberta Health's claims system. Allowing claims only when there is an established relationship between the physician and patient would help ensure that the code is used appropriately, as the physician would be aware of the patient's history and medical needs.

Proposal 3 - De-Insure driver medical exam for patients 74.5 years or older

Alberta Health proposes to de-insure driver medical exams for patients aged 74.5 years of age or older, under the rationale that these services are not medically necessary.

As required by the Traffic Safety Act, patients 74.5 years and older must have a physician complete a medical examination and form on their behalf in order to maintain their driver's license. Patients must have this completed again at age 80 and every 2 years thereafter.

This has been an insured medical service in some form as far back as 1977 (A-27 Senior citizen driver's examination - including completion of form (required after 69th birthday)).

Younger patients with medical conditions that require frequent medical review in order to maintain their driver licenses must pay for this service on their own. However, this expense can be attributed to the person's medical expenses which is a tax deductible item.

Alberta Health has estimated savings of $4.4M, most of which ($4.3M) is attributed to the Section of Family Medicine.

AMA's Position

This code is not unique from the perspective that there are other non-medically necessary services funded through the SOMB. For example, the SOMB has listed fees for services required under the Personal Directives Act, Mandatory Testing and Disclosure Act, Certification under the Mental Health Act; all of which were funded by AH as a result of the legislative requirements placed on physicians.

The AMA recognizes that the Minister of Health has jurisdiction to determine what constitutes an insured medical service. Physicians will be on the "front lines" of this change and expect significant push-back from seniors. The AMA strongly recommends that the Minister engage in public consultation before implementing this initiative.

Key Themes from Physicians:

- This should be sent out for public consultation.
- Unfair treatment of seniors.
- Many patients will choose not to have this done and drive without a license.

Key Quote:

"I work in rural Alberta where I see many complex elderly patients. Many patients live out of town and rely on driving to participate in social activities, attend appointments and access services such as grocery stores. Adding a fee for their driving test would be a barrier to their independence, health care and social activities and will negatively impact my patients' quality of life. We should be empowering seniors to stay connected in the community and often driving is the only way to get around effectively where I practice."

Impact or Potential Unintended Consequences

- Some patients may not be able to afford the cost of the service.
- Seniors' mobility could be impacted, particularly in areas where there are few options to driving.
- Physicians may choose to provide this service to patients in conjunction with another insured service, which will not result in desired savings. I.e., this assessment will be combined with another insured patient visit, resulting in a similar expenditure.
- Varying costs may lead to patients clinic shopping in order to obtain the best price. This is problematic from the perspective that the patient's family physician is in the best position to provide an accurate and reliable assessment of the patient's condition. Physicians who do not know the patient's history and complicating factors may not be able to provide a realistic assessment of the patient's cognitive and physical abilities.

AMA's Advice

The government should explore other mechanisms (e.g. Saskatchewan's funding through registration fees) to fund this item outside of the SOMB.

The public should be fully engaged in any decision to de-insure this item.

Proposal 4 - De-insure diagnostic imaging services referred from uninsured practitioner referrals

Alberta Health has proposed to disallow uninsured practitioners from referring for insured diagnostic imaging services. This would preclude billing for services referred to radiologists from chiropractors, physical therapists and audiologists.

The original requests to allow these diagnostic imaging referrals (as well as specialist consultation referrals) came from Alberta Health. They were positioned as cost savings items, due to the potential to reduce family physician visits. In 2008, AH completed an analysis of the impacts of adding chiropractors to the referral list, reporting savings of $45,000 in family medicine referral costs. AH continued to add providers to the "referrals required" list, including audiologists and physiotherapists, provided they were recognized under the Health Professions Act. Their rationale was that direct-to-diagnostic provided more timely care, and saved the cost of a GP visit.

Somewhat contrary to this previous rationale, Alberta Health has estimated that removal of these referrals would save $7.2M. Most of the savings would come from reduced chiropractor referrals.

AMA's Assessment

The AMA recognizes that the Minister of Health has discretion to determine that such referrals are uninsured.

It's unlikely that these would be billed to patients as uninsured services. Patients will either be sent to family physicians for referral, or the diagnostic tests won't be ordered.

If the patient is sent to their family physician, the physician would typically examine the patient first and confirm the diagnosis prior to determining if there was a need for further diagnostics. Therefore it is likely that a visit by a physician will be claimed whether a referral for diagnostics is generated or not.

It's difficult to accurately estimate cost savings, as this policy change will result in some combination of reduced imaging and increased patient visits.

Impact or Potential Unintended Consequences

There are several impacts and potential unintended consequences:

- Potentially fewer DI imaging referrals overall.
- Potential reduction in inappropriate referrals.
- An increase in family physician visits and DI referrals.
- Potential increase in the time these patients wait for tests.
- Routing referrals through the family physician may improve primary care coordination and continuity.

AMA's advice

The AMA is of the opinion that the public should be engaged in any such decisions to de-insure services.

Proposal 5 - DI Billing Appropriateness

Alberta Health has proposed to clarify the rules and restrictions to ensure accurate billing practices related to DI imaging services.

It appears that most items in this proposal were taken directly from the Section of Diagnostic Imaging's 2017 allocation submission that was discussed with Alberta Health in 2018 and early 2019. These items were ultimately pulled from consideration, as Alberta Health rejected the notion that any proportion of the estimated savings could be reinvested in the DI schedule (and despite AMA's efforts to introduce a shared savings strategy and policy to monitor and adjust costs if actual costs varied from estimates).

The estimated changes to payments would be $9.2M, $9.1M (about 2% of the DI base) directly from Radiology and $140K from Obstetrics and Gynecology.

AMA's Position

Within the current rules, physicians are able to bill for these services when they are provided in combination. This collection of amendments effectively changes the rate of payment for some services and should therefore be moved to current processes under the AMA Agreement and/or the bargaining table. At those tables, further consultation with the section is required to avoid unintended or unknown consequences.

The AMA recognizes that there are some instances where improvements can be made in determining what codes can be claimed in combination.

Key Themes from Physicians

- There are clinically appropriate situations where X320 and X324 services should be billed together and have unrelated diagnosis. One is fetal concerns and the other is maternal.

Impact or Potential Unintended Consequences

- This approach – to disallow any savings reinvestments and then to later make unilateral amendments that withdraw funding from the SOMB - will have a "chilling effect" on sections' SOMB modernization efforts, as it will discourage them from identifying potential shifts in funding from lower to higher valued services.

- This type of proposal is damaging to the trust relationship between AH and physicians.

AMA's advice

A joint AMA/AH shared savings policy should be established to govern SOMB amendments to address ambiguity or lack of clarity in the schedule. Where codes are unclear, not all billing patterns are inappropriate and sections should be given the opportunity to redistribute at least a portion of funding between existing and new items.

A joint AMA/AH monitoring and adjustment strategy should be in place to provide clear expectations and outcomes for all stakeholders making significant SOMB changes.

Consultation with the appropriate medical specialties is required to insure that barriers to care are not being created as a result of targeted code changes as opposed to a comprehensive review of a modality.

Proposal 6 - Daily Caps

AH has proposed to implement a daily cap on patient visits, with 50% discounting of visit services between 51 and 65 visits per day, and 100% discounts (zero payment) for visits in excess of 65 visits per day. Alberta Health's rationale is that physicians who provide excessive visits per day may compromise their own health and safety as well as patient care.

AH has stated that this cap will include ALL "V" category codes that are billed in location types POFF (office) and RCPO (Regional Contract Practitioner Office). This proposal will NOT be applied to rural and remote communities (claims eligible for RRNP Variable Fee will not count to the threshold).

Alberta Health has estimated cost savings of $26M. The AMA estimates maximum savings of up to $15.5M, though it's likely to be much lower due to shifts in service activity and unintended consequences.

AMA Position

This item represents a significant change in physician compensation and should therefore be moved to current processes under the AMA Agreement and/or the bargaining table. At those tables, further consultation with sections is required to avoid unintended or unknown consequences.

The B.C. capping limitations includes only services equated to Alberta's 03.02A, 03.03A, 03.04A and 08.19G. Alberta Health's proposal would have a much larger impact, as it includes all "V" category codes including: telephone calls,13.99J medical emergency detention time, all electronic communication codes, all family and team conference codes, time extenders on complex care (03.03FA, 03.08I, 03.08J), and all obstetrical and oncology visit services.

In 2015, the Section of Family Medicine extensively studied the concept of a daily cap on the number of payable visits, engaging its membership in the discussion. The section spent

considerable time contemplating the merits of such a proposal and the consequences and/or impacts that would result in the implementation of the cap. The section's draft proposal underwent several iterations to prevent unintended consequences. Capping was ultimately seen as impractical, as it would need to balance many dimensions/considerations, including:

- The time frame in a day when the service is provided (e.g. 50 services delivered in 4 hours is much more problematic than 60 services in 12 hours).
- The visit services being provided (not all visit services take the same amount of time).
- The availability of physicians to provide the service (e.g. is a physician also covering patients for a colleague who called in sick, or on holidays and no locum coverage is available).
- Patient care alternatives once a cap is reached (i.e. will patients be forced to seek care in emergency rooms?).
- The frequency with which a cap is reached (one day per year is very different than 200 days per year).
- The capability of Alberta Health's claims system to accommodate these considerations

In its place, the Section of Family Medicine proposed a strategy to link compensation for visit services to patient continuity/attachment, once the central patient attachment registry (CPAR) and Alberta Health's claims system could enable the development of attachment modifiers and differential rates of payment.

Key Themes from Physicians

- A blanket cap of 50 patients per day may not make sense across all specialties, as some specialties have organized themselves to be efficient in order to accommodate a growing waitlist.
- Patients will be referred to the emergency department
- A limit on 'V' category services is very different than 50 patient encounters per day
- This coupled with the changes to the complex modifier will result in the unravelling of the patient medical home

Key quote:

If a daily cap was implemented, I would be forced to discharge many patients from my practice, in order to accommodate only the most urgent new consultations and only the most aggressive chronic eye conditions. As eye care is beyond the scope of primary care providers, the discharged patients would be forced to see non-physician eye care providers such as optometrists and opticians, who are not well equipped or trained to treat more than the most basic eye conditions. I hope that the AMA will strenuously object to the proposed daily caps, as such a proposal will inevitably result in decreased specialist access for many patients.

Impact or Potential Unintended Consequences

Unintended consequences may include the following:

- Reduced access to care.
- Fragmented care, as patients seek services elsewhere.
- A reduction in lower cost services (if physicians are capped, they are more likely to bill the higher cost services they provided to patients in a day).
- No consideration for special circumstances (e.g. short term physician shortages in a practice).
- Patient care could be driven to more expensive environments such as UCC/ACCC, and Emergency Rooms.

AMA's advice

The AMA supports the underlying goal to ensure that patients receive quality care and physicians are providing a safe number of visit services. In the AMA's view, the government's proposal is unlikely to achieve this objective and may create several unintended consequences.

More consideration and consultation with B.C. should be explored to verify claims that physician well-being and patient safety have improved with a cap.

This will have rate implications to membership ($/day) and therefore must be negotiated with the profession. Sections should be further engaged in meaningful consultation and the design of any policies to limit visit services.

Any proposal must allow for exceptions.

Proposal 7 - Overhead

Alberta Health has proposed to separate overhead from all hospital-based services under the rationale that it would support equitable payments for physicians. This proposal includes the removal of a facility-based overhead cost component for selected health service codes.

AH estimates cost savings of $83M (about 2% change in the base) starting in 2020/2021.

The AMA requires further information regarding the myriad of known and (currently unknown) arrangements in order to fully assess this proposal and cost estimate.

Key Physician Quote

…Obstetrician Gynecologists who run our clinics out of the Hospital pay overhead at a rate equitable to our colleagues who run practices outside of the hospital. We have a tray fee deducted from our in office procedures. This is fair as the hospital does our sterilizing. We will need to move our practices out of the hospital if the proposed fee change goes ahead as we will continue to be charged overhead and our consultation fees will be reduced as we are in an AHS facility. This negatively impacts patient care as we will no longer be immediately available for stat calls to labor and delivery when a second obstetrician is emergently needed nor will we be available for stat calls to the ER when a gynecologist is immediately required.

AMA's Position

This item represents a significant change in physician compensation and should therefore be moved to current processes under the AMA Agreement and/or the bargaining table. At those tables, further consultation with sections is required to avoid unintended or unknown consequences.

This proposal does not account for the significant complexities of overhead in AHS facilities, including the following:

- AHS resources provided to physicians vary significantly and may include subsidized office space, staffing and/or equipment.. Physicians often pay additional expenses out-of-pocket to run their practices.

- A number of physicians pay overhead recovery amounts to AHS and/or universities and these vary considerably by community, facility and section, making it difficult or impossible to design differential fees.

- AHS sometimes receives in kind services in return (e.g. in-house coverage in return for subsidized office space).

- It is not appropriate to assume that services are the same in community and in hospital. Individual fees paid for physician services typically account for time, intensity, complexity, and overhead costs. Each of these components may change depending on service location. While overhead may be less in hospital, the physician may spend more time with that patient and the patient may be more complex and/or intense. Thus the compensation components could be different for different settings.

The joint AMA/AH/AHS Physician Compensation Committee has recognized that current 2009 overhead estimates are out of date and that there were significant issues adapting more recent Deloitte estimates for use in Alberta. The AMA is leading work on new and more accurate estimates for the PCC's consideration by December 2020. Currently there are no section overhead estimates that stakeholders accept as credible.

The AMA has low confidence that any party would be able to calculate an accurate OH component that would capture the complexity of current payment arrangements.

Impact or Potential Unintended Consequences

- As AHS overhead arrangements vary across the province, proposed changes would unfairly disadvantage some physicians or some locations.

- AHS contracts will require renegotiation and re-evaluation for relevance.

- Physicians may choose to do more services in the community where the services will be billed to the Physician Services Budget.

- Deducting overhead amounts from services provided in AHS facilities may inappropriately remove physician compensation that supports their community office, e.g., if physicians leave their offices during the day to attend to patients in the emergency room, they still incur overhead expenses in their clinics.

- Specialists and rural family physicians providing emergency coverage are expected to be the most impacted by these changes.

- Deducting community-clinic overhead amounts from hospital work would undervalue professional services in cases where the time, intensity and complexity of the service is greater in the hospital than in the community.

AMA's advice

This item represents a significant change in physician compensation and should therefore be moved to current processes under the AMA Agreement and/or the bargaining table. At those tables, further consultation with sections and physician groups is required to avoid unintended or unknown consequences.

The AMA recommends a complete review of physician overhead provided in AHS facilities before this initiative could be considered.

Proposal 8 - Clinical Stipends provided through AHS

Alberta Health has proposed to eliminate stipends paid to certain AHS-contracted physicians effective March 31, 2020. The stated rationale is that clinical stipends for physicians paid by AHS are for insured services and therefore are inappropriately compensating physicians for services they are already paid to provide through the Schedule of Medical Benefits.

Like other provinces, AHS has used clinical stipends in the form of supplementary payments, income guarantees, etc. for decades to recruit and retain physicians in areas of practice where:

- There is significant variability in ability to bill.
- There are challenges in recruiting physicians to fill the desired/needed role.
- The number of physicians required to maintain a reasonable call schedule is greater than the number of physicians required to appropriately serve the patient population, resulting in a reduced ability to have an appropriate and attractive income when compared with other locations.
- To remunerate physicians for services in which the SOMB provides minimal or no remuneration (e.g. in house availability, etc.).

Alberta Health estimates savings of $55M. At present, the AMA has not received information from Alberta Health or Alberta Health Services regarding the specific groups that would be impacted, making it difficult to comment on this item.

The AMA does not have current figures for the total number of AHS program payments. In 2014/15, there were 347 programs, not including Physician On Call (POC), Calgary Laboratory Services (CLS) or Diagnostic Imaging (DI), with 3216 physicians participating. Total AHS expenses for these groups was $187.3M. Assuming funding has been flat since 2014/15, this change would represent a 29.4 percent reduction in funding.

AMA Position

Some limited information was provided by Alberta Health Services on December 17, which showed the number of physicians impacted by section (second table in Appendix B). The AMA

has not been provided with a list of specific groups impacted, as well as the financial impact on these groups. In the AMA's view, there has been insufficient information provided to consult our members appropriately.

The AMA does not accept the position that these clinical stipends are inappropriate, as they are not typically tied to an individual insured service provided to an Alberta beneficiary.

The AMA interprets this initiative as a compensation matter which must be negotiated under the terms of the Strategic Agreement.

The AMA rejects the notion that Alberta Health can unilaterally make policy contrary to the Strategic Agreement.

In the AMA's view, this would violate the Physicians' right to meaningful association under 2d Charter of Rights and Freedoms.

ARPs may not be a viable replacement, at least in the short term. Stipends are meant to remunerate and recognize physician services related to total patients that are not recognized in the SOMB (e.g., for uninsured or non-insured clinical services). ARPs, with their focus on clinical service provision will not address the many reasons that clinical stipends are paid. In addition, AH has had great difficulty in moving forward with ARP proposals on a timely basis, which makes it very difficult to see that the April 1, 2020 timeline could reasonably be met by AH.

Key Themes from Physicians

- AH, AMA and AHS should review the clinical needs and the coverage needs being satisfied by physicians providing coverage and receiving the stipend and then determine if it is still wise to remove the stipend.
- Some physician groups were recently involved in arbitration regarding the stipend and the award went in favor of the physicians as it was proven that the services that they are providing are not covered by the SOMB.

Key quote

I currently am a hospitalist, I am seeing a significant increase in patient complexity as well as a bureaucracy created work load which is not compensated. The impact of on call is underestimated. The complexity and acuity of patients is mind boggling compared with 10 years ago. Many of the proposed changes reduce payments in exactly those pressure points - emergency, internal medicine and unattached patients. My time is increasingly poorly compensated and I may be one of the fortunate physicians who can retire from practice in the face of an increasingly dysfunctional system. I did not go into this profession to be a "widget maker" producing a certain volume of product within the confines of an ever speeded up assembly line.

Impact or Potential Unintended Consequences

If stipends are removed the result may be:

- Difficulty recruiting or retaining these physicians
- Reduced access
- Decreased services
- Program closure

This type of unilateral change could have a detrimental impact on AHS recruitment and retention efforts in the future, as any physician signing them would know they could be reduced or eliminated with little warning and no negotiation.

AMA's advice

If new rates or compensation amounts are sought, these must be negotiated through the terms of the Strategic Agreement as intended.

Under the Strategic Agreement, AHS has an obligation to notify the AMA and the physicians involved. Physicians have the right to choose their representatives for negotiations.

Proposal 9 - Submission of claims within 60 days of service

AH is proposing to reduce the claims submission deadline from the current 180 days to 60 days. Health Practitioners currently have 180 days from the date of service, or from the date a patient was discharged from the hospital, to submit fee-for-service claims. AH will reduce the limitation period to 60 days for FFS claims submission.

This has been put forward as a zero cost saving item, however, Alberta Health staff have indicated that approximately 5% of claims are received between days 61-90. It's reasonable to assume that some of these would not be paid with a 60 day submission period.

AMA Position

- A 60 day limit to submit for payment is not consistent with any other province and would be unfair to physicians, as the government would effectively pay physicians $0 for the insured services they provided to Albertans over 60 days prior to billing. It is difficult to conceive of anywhere in industry where a supplier/contractor would be paid $0 for an invoice for services submitted after 60 days.

- In recent years, Alberta Health has taken a very restrictive stance on the exceptional circumstances whereby the limit might be extended (typically only in cases of fire, theft, and flood). In a recent case, a physician was denied over $45,000 in claims that were submitted within the 180 day period but failed to fully transmit due to technical issues between the physician's EMR and Alberta Health's claims system. This stance is incompatible with a shortened timeframe and may create significant hardship for some physicians.

Key Themes from Physicians

- Changes to the claims system are required; claims can no longer be held for the entire time frame whether it is 60 or 90 days and then refused and not eligible for resubmission as they are out of date.
- Significant lead time is required for changes.
- Reconciliation between AH and WCB billings need to occur more frequently and more timely.

AMA Recommendation

While not fully agreeable with a reduction in the claims period, any adjustments to the timeframe should be in line with other provinces, e.g., 90 days. The AMA would also recommend:

- Significant notice of any change be provided to physicians.

- Any change be accompanied by more flexibility in assessing exceptional circumstances around stale dated claims.

- Some level of consultation with billing providers and EMR vendors to determine whether or not the timeframe is reasonable.

- Improvements be made to Alberta Health's claims system to improve error checking with EMR systems and maintain a record of refused claims so that corrections may be made within any prescribed time frame.

Proposal 10 - Non-invasive Diagnostic Fees in AHS facilities

Fees paid for non-invasive diagnostic tests such as ECG, EEGs, echocardiography, etc. performed in AHS facilities currently differ from facility to facility. AH has proposed to standardize all AHS fees paid (except where there is an existing commitment between AHS and practitioner) for non-invasive diagnostic tests performed in all AHS facilities, to match the fees Alberta Health pays in the Schedule of Medical Benefits.

It is currently unclear how physician payments will change because AMA has not been provided with the rates paid to providers who hold contracts with AHS for services.

AMA Position

The AMA interprets this initiative as a compensation matter which must be negotiated under the terms of the Strategic Agreement. The AMA rejects that notion that Alberta Health can unilaterally make policy contrary to the Strategic Agreement. In the AMA's view, this would violate the Physicians' right to meaningful association under 2d Charter of Rights and Freedoms.

Key Themes from Physicians

- Need further information in order to comment.

Impact or Potential Unintended Consequences

If payments are unilaterally reduced, this may lead to difficulty finding physicians willing and available to provide the services. The result would be reduced patient access/increased wait times for tests, which could ultimately result in higher costs to the health system.

To maintain service levels, there may be instances whereby contract rates must be increased as it is not suitable to move all contracted rates to the lowest common denominator.

From a broad perspective, this type of unilateral change could have a detrimental impact on AHS' ability to contract for such services in the future. Any physician entering such arrangements would know that payments could be changed in the future with little warning and no negotiation.

This may result in off-loading of services from AHS to the Physician Services Budget or vice versa.

AMA Recommendation

Changes in AHS payment rates should be negotiated under the Strategic Agreement. Under this framework, AHS has an obligation to notify the AMA and the physicians involved. Physicians have the right to choose their representatives for negotiations.

Proposal 11 - Stop accepting Good Faith Claims

Alberta Health has proposed eliminating its Good Faith Policy which pays claims on a limited basis for Alberta residents who cannot provide proof of coverage at the time of service.

Alberta Health has estimated that this policy change would save $2.1M in 2020/21. The AMA is unable to estimate the impact on various sections, however, it is expected to disproportionately impact those who provide emergency care in AHS facilities.

AMA Assessment

While positioned as a policy decision, this is a devaluing of physician services for patients that present to AHS facilities and require care. In such circumstances, a physician is expected to provide the service for free when they're unable to confirm Alberta health care coverage.

The Alberta Health, *Physicians Resource Guide 2018* states that "The Good Faith Policy was developed to minimize the risk of Alberta practitioners not being paid for service provided to Alberta residents who the practitioners believes are eligible for coverage under the AHCIP at the time of service but cannot provide proof of coverage." This is consistent with the Hospital Act (Section 38 (3)). This policy does not apply to non-residents of Alberta or out-of-country patients. This policy is also consistent with AH's application of payment when physicians are required under legislation to provide services Section 38 (4) of the Hospital Act. The Act also states that: "Notwithstanding anything in this or any other Act, no person shall, in an emergency, be refused admission to an approved hospital or be refused the provision of any services by an approved hospital by reason only of the fact that the person is not entitled to receive insured services."

Other provinces that have done away with Good Faith type policies often have non-fee-for-service remuneration models in place (e.g. for ER physicians), which significantly reduces the impact on physicians.

Impact or Potential Unintended Consequences

- The AMA is concerned with the impact of this change on healthcare provided to inner city marginalized populations who do not often carry health care cards. This group has some of the most complex needs and requires significant physician resources.

- This policy change would significantly disadvantage physicians who practice in emergency rooms, ICUs, provide inpatient services, and provide services to people without health care insurance. Typically those who can't produce evidence of health insurance are also unable to pay for their services, leaving physicians in the situation of being required by the Act to provide services for which they will not be paid, but will be medically-legally liable.

AMA's Recommendation

Application of the Good Faith policy could be significantly reduced with increased efforts by AHS to ensure proper registration of patients at admission, triage or registration.

Onsite real time registration for the transient or homeless population should be made available.

The development of health care cards with security functions should be mandatory.

Patients should be educated regarding the importance of registering and maintaining their health care coverage as many simply don't think it's important.

Key Physician Quote

While I would agree in my office it should be my responsibility to confirm AH coverage, I have NO control over unassigned patients presenting to the emergency while on call, nor any patient that I am requested to consult on whilst on call. Many of these patients are not in state where confirmation can occur, i.e. multiple fractures, urgent need for care etc. Don't feel the onus for collection should fall on me just because I have the ethical duty to provide care, and it turns out later the patient was not covered. AH and AHS should be more diligent in ensuring each and every Albertan has done the requisite paperwork and is covered under the plan. Makes us the villains regarding financial matters for this and it is linked to the most vulnerable populations.

Appendix B - AMA Estimates of Consultation Proposal Savings, By Section

December 18, 2019

Data is for the year ended March 31, 2019

More information to proposal 5 and 7 by AH

Specialty	Proposal 1 - Complex Modifiers *incl. CMXV15, CMXV20, CMGP01,CMXC, BCP*	Proposal 2 - Comprehensive Annual Care Plans *incl. 03.04J, 1/4 of visits, BCP*	Proposal 3 - Driver Medical Exam for patients 74.5 years or older *incl. 03.05H, BCP*	Proposal 4 - De-insure DI services referred by a non-insured or non-publically funded practitioner	Proposal 5 - DI Billing appropriateness *incl. X301, X303, X311, X315, X316, X317, X318, X319, X320*	Proposal 6 - Daily Caps *51 - 65 = 50%, >65 = 0 payment*	Proposal 7 - Overhead	Proposal 9 - Submission of Claims within 60 days of Service	Proposal 10 - Stop Accepting Good Faith Claims	Total	FTE Counts (SAE)	Total Per FTE
Anaesthesiology	$513,992	$0	$0		$0	$250,148	$0	The rest of the country is on 90 days.	Communi-cation will need to go to patients so that they carry their AHCIP Card with them to all visits. Issues with Hospital claims, especially emergency room.	$764,140	382.0	$2,000
Cardiology	$1,288,746	$0	$86		$0	$2,392	$3,024,585			$4,315,809	115.5	$37,366
Cardiovascular & Thor. Surg.	$45,430	$0	$0		$0	$0	$0			$45,430	12.6	$3,606
Critical Care Medicine	$95,898	$0	$0		$0	$0	$0			$95,898	54.9	$1,747
Dermatology	$267,667	$0	$0		$0	$517,102	$21,554			$806,323	49.6	$16,257
Emergency Medicine	$4,392,330	$0	$0		$0	$0	$0			$4,392,330	362.1	$12,130
Endocrinology/Metabolism	$191,858	$0	$0		$0	$0	$103,308			$295,166	6.6	$44,722
Gastroenterology	$484,472	$0	$0		$0	$8,588	$1,625,565			$2,118,625	47.2	$44,886
General Practice	$173,377,125	$46,317,171	$4,370,185		$2,786	$10,300,019	$19,411,914			$253,779,201	4,195.7	$60,486
General Surgery	$1,131,822	$0	$0		$0	$0	$3,025,172			$4,156,994	166.3	$24,997
Generalists Mental Health	$0	$0	$0		$0	$0	$0			$0	13.2	$0
Infectious Diseases	$94,125	$0	$0		$0	$0	$0			$94,125	17.0	$5,537
Internal Medicine	$4,815,640	$0	$15,421		$0	$56,718	$9,045,595			$13,933,375	348.1	$40,027
Nephrology	$198,091	$0	$86		$0	$1,143,271	$242,144			$1,583,591	29.4	$53,864
Neurology	$946,142	$0	$0		$0	$0	$1,458,279			$2,404,420	60.0	$40,074
Neurosurgery	$50,362	$0	$0		$0	$511	$12			$50,884	7.1	$7,167
Obstetrics & Gynaecology	$2,923,778	$0	$0		$140,098	$161,088	$1,554,491			$4,779,455	236.6	$20,201
Ophthalmology	$577,569	$0	$0		$0	$3,037,700	$269,648			$3,884,917	123.8	$31,381
Orthopaedic Surgery	$1,544,330	$0	$0		$0	$7,516	$2,350,983			$3,902,829	160.4	$24,332
Otolaryngology	$677,109	$0	$0		$0	$350	$331,757			$1,009,217	63.2	$15,969
Paediatrics	$3,603,788	$0	$0		$0	$4,197	$3,665,765			$7,273,749	256.8	$28,325
Pathology	$30,254	$0	$0		$0	$0	$70,863			$101,117	3.8	$26,610
Physical Medicine & Rehab.	$838,511	$0	$0		$0	$17,265	$501,579			$1,357,355	41.1	$33,026
Plastic Surgery	$262,647	$0	$0		$0	$0	$1,621,173			$1,883,820	62.1	$30,335
Psychiatry	$629	$0	$0		$0	$10,149	$12,278,958			$12,289,736	497.5	$24,703
Radiology	$33,782	$0	$0	$7,000,000	$9,113,396	$0	$105,953			$16,253,131	291.2	$55,814
Respiratory Medicine	$880,518	$0	$0		$0	$0	$713,338			$1,593,855	43.0	$37,066
Rheumatology	$66,160	$0	$0		$0	$0	$57,703			$123,863	5.2	$23,820
Thoracic Surgery	$109,558	$0	$0		$0	$0	$282,955			$392,513	12.9	$30,427
Urology	$623,188	$0	$0		$0	$6,523	$1,329,374			$1,959,085	56.2	$34,859
Vascular Surgery	$137,575	$0	$0		$0	$0	$85,032			$222,607	14.5	$15,352
Total	$200,203,094	$46,317,171	$4,385,778	$7,000,000	$9,256,280	$15,523,536	$63,177,700	$0	$0	$345,863,559	7,735.6	$44,711

RRNP has not been calculated as we do not have exact location of the physicians

FFS only

For Propsal 8, see the following page

Alberta Health Services

Proposal 8: Clinical Stipends Provided By AHS
Summary Information
December 17, 2019

Alberta Health Services (AHS) is considering a proposal to eliminate payments made to physicians that are in addition to the Fee for Service (FFS) billings eligible through the Schedule of Medical Benefits (SOMB).

Currently there are 274 programs across the province with every Zone having some form of a clinical stipend program for physicians.

Summary information on the programs that have been identified and are currently being considered by AHS to end are below and total approximately $16.8M annually in savings.

Department	Zone	Number of Programs	Approximate Number of Physicians Impacted	Effective End Date
Anesthesia	Edmonton North	2 1	100	February 29, 2020 March 31, 2020
Emergency Medicine	Provincial Calgary Central Edmonton North	1 1 1 1 2	300	March 31, 2020
Family Medicine	Edmonton	1	15	March 31, 2020
Medicine (MRP) Inpatient Coverage	Calgary Edmonton Edmonton North South	1 3 7 2 1	200	March 31, 2020 December 31, 2019 March 31, 2020 March 31, 2020 March 31, 2020
Obstetrics	Edmonton Edmonton	1 1	45	December 31, 2019 February 29, 2020
AHS Funded On Call Programs (will be reviewed under the POCP Review)	Calgary Central Edmonton South	2 1 4 3	70	March 31, 2020
Orthopedics	Edmonton	1	3	February 29, 2020
Palliative Care	South	1	12	March 31, 2020
Pediatrics	Calgary Edmonton	1 2	12	March 31, 2020
Public Health	Edmonton	1	10	March 31, 2020
Surgery	Calgary Edmonton Edmonton South	3 2 4 1	150	March 31, 2020 February 29, 2020 March 31, 2020 March 31, 2020
Non-MRP Inpatient Coverage	Edmonton	11	50	March 31, 2020
Total		**63**	**967**	

* Psychiatry and Oncology Stipend Programs are not included in the table below as they are still being reviewed by AHS.
** There are additional clinical stipend programs that are currently being reviewed and assessed for transition to clinical ARPs or there may be a service delivery model change required before the program can end. These are not included in this list.

MCLENNAN ROSS LLP
LEGAL COUNSEL

Our File Reference: 185468

Jonathan P. Rossall, Q.C.
Direct Line: (780) 482-9216
e-mail: jrossall@mross.com

Candace Niven, Assistant
Direct Line: (780) 482-9310
e-mail: cniven@mross.com

Fax: (780) 733-9711
PLEASE REPLY TO EDMONTON OFFICE

December 18, 2019

SENT BY E-MAIL

ALBERTA MEDICAL ASSOCIATION
12230 106 AVENUE NW
EDMONTON, AB T5N 3Z1

Attention: Jim Huston/Alan Florizone

Dear Sirs:

Re: AMA/AH Negotiations - Consultation Issues

You have asked for our opinion on the question of whether some or all of the proposals regarding "Insured Services Consultation" put forward by AH in the course of negotiations are actually items for consultation with the AMA, or are they in fact rate changes that qualify as issues for negotiation between the parties. The AMA has taken the position that many of these items are, in fact, rate changes and while it is prepared to go through the consultation process, we are reserving the right to keep these matters on the table during negotiations.

Not surprisingly, government takes the view that these are "rule changes" or that they relate to AHS' responsibilities and therefore there is only an obligation to consult with the AMA (amongst other groups) before implementation. It is true that some of the proposals (such as cutting off the right for other health care professionals to refer) do not appear to relate to "rates" payable to physicians, but others in our view clearly do.

The starting point of the analysis is to look at AMA's legislated recognition. As you know, our recognition clause obliges the Minister to recognize AMA as "...the exclusive

representative of physicians on "compensation matters"". That term is defined as meaning "...the rates for benefits payable for the provision of insured services by a physician."

Again, as you are aware, rates for the payment of medical benefits are established in the Schedule of Medical Benefits (in the non-ARP world).

Clearly any effort on the part of government to unilaterally change a fee in the SOMB would be met with a cogent argument that that would be a rate change and would be subject to negotiation with the AMA (and, ultimately, be put before the Physician Compensation Committee for consideration).

In our view AH is trying to do an end run on this by purporting to modify rules relating to SOMB rates. So, for example, they are purporting to change the rates relating to "Complex Modifiers" by increasing the time requirements with a complex patient so as to reduce the number of visits.

Another example would be changes proposed regarding diagnostic imaging based on a principle of "billing appropriateness". The changes to "code-stacking" are, in fact, rule changes but they affect how physicians submit billings to the SOMB.

In our view, while rule changes are not specifically found in the SOMB, that does not end the discussion. The bottom line is that under the *Alberta Health Care Insurance Act*, while the Minister is ultimately responsible for approving (not setting) rates for payment, his obligation is to administer and operate a plan to provide benefits for basic health services to Albertans. It would be our opinion that in analyzing what "compensation matters" are, those matters relate directly to how benefits are paid for benefits for basic health services. Physicians are paid by government to provide those services. Part of the equation that goes into determining what physicians are paid is the rate found in the SOMB coupled with rules that apply to those visits. Those are, in our view, "compensation matters" which modify or are attached to the "rates for benefits payable".

So again, for example, if an 03.04A visit with a patient yields a fee of $xx, that number is the rate per visit. But, if the physician is restricted by the rules to provide only four 03.04A's a day, then clearly the compensation ultimately payable to the physician is affected. To properly compensate for that rule, the "rate" would have to be increased to allow for the same net compensation. So in my view, changing a rule regarding how a rate is utilized effectively amounts to a "rate change".

It would be the same of government said, "we are limiting the 03.04A to 10 services per week, and any comprehensive assessment billed over this threshold will be reduced to an 03.03A". This would effectively reduce the average price of an 03.04A to something less than the current fee.

This is a similar analysis to the one AMA did for PCC when government was proposing to change the definition of "FTE". While the rate or payment per FTE didn't change, the fact that an FTE was now required to work "9" hours a day as opposed to "8" hours (for example) effectively reduced the rate. I believe PCC accepted jurisdiction in that matter.

Therefore, in our opinion, the manner in which "rates" are paid fall within the scope of "compensation matters" and are therefore subject to the requirement to negotiate those changes with the AMA.

So, I believe that you are justified in responding to AH's position regarding the consultation issues by stating that in your view, based on legal advice, anticipated changes to those rules amount to indirect rate changes which clearly fall within the AMA's jurisdiction to negotiate under s. 40.1 of the Alberta Health Care Insurance Act.

Yours truly,

JONATHAN P. ROSSALL, Q.C.

JPR/cmn
00185468 - 4133-1760-1825 v.1